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Orsett Psychological Services
PO Box 179
Grays
Essex
RM16 3EW

orsettpsychologicalservices@phonecoop.coop

CONTENTS

THEORETICAL IDEAS TO EXPLAIN BEHAVIOUR: PRELIMINARY THOUGHTS ON TWO MODELS

In this article, I introduce the first thoughts on two models to explain different aspects of behaviour:

i) Degrees of autonomy and determinism

Behaviour needs to be understood in terms of the factors that influence autonomy and determinism, the choices available, and the meaning of these to the individual.

ii) Self-esteem equilibrium and "self-sabotaging behaviour"

For some individuals there is a maximum level of positive experiences, and when this is reached it triggers "self-sabotaging behaviour" to re-establish a negative situation.

1. DEGREES OF AUTONOMY AND DETERMINISM

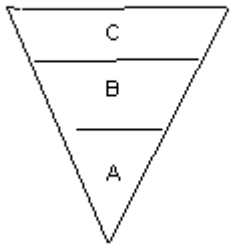
Finding the reason for individual behaviour is the core of psychology. But related to this concern is whether the individual chooses to do the behaviour or was it in some way determined. In psychology, this is known as the autonomy-determinism debate.

In the simplest form, behaviour is either chosen or determined. In reality, it is more sophisticated than a simple dichotomy. I want to propose that the emphasis should be upon autonomy and choice, and the factors that limit these.

In figure 1, the idea of an upturned triangle shows the general categories for understanding, though it is really a matter of degrees. In situations of category A, individual behaviour is mostly determined, and there is limited choice and autonomy (eg an individual with severe physical disabilities).

At the other extreme, category C, individual behaviour here has few restrictions or determinants (eg very wealthy and physically healthy individual). As to whether an individual is completely free is a philosophical question.

The middle category, B, is where individuals face restrictions and determinants upon their choice and autonomy. Overall, the higher up the upturned triangle, the greater the opportunity for autonomy.



A = Behaviour is determined with little choice or autonomy
B = Choice and autonomy are limited by various factors
C = Few restrictions or determinants on choice and autonomy

Figure 1 - Autonomy and determinism as an upturned triangle.

Stevens (1996a) proposed that the ability to envisage alternatives and to have reflexive awareness are the basis of autonomy. He emphasised the role of education and multiple media offering alternative viewpoints as well as the notion of democracy in encouraging reflexive awareness. But "the capacity to act on the basis of reflexive awareness is fragile at best and is easily dominated by other modes" (p80).

So what are the factors involved in determining or restricting behaviour? There are many and they vary depending upon the situation or behaviour. Table 1 lists the factors.

It is likely that more than one set of factors will be working at the same time. For example, an individual living poverty with physical health problems and lack of education is limited in their autonomy. The more factors that restrict autonomy, the less room that an individual has to choose their behaviour and the flexibility to choose alternatives. For instance, an individual with low intelligence, limited language and problem-solving skills, and few social opportunities is "driven" to offending behaviour. Almost completely their behaviour is determined.

The purpose of this model is to help understand the individual's "decision" to do a particular behaviour. Knowing the factors influencing determinism and autonomy helps in understanding the reason for the behaviour. For example, the stealing of food is different between an individual who is starving and in poverty, and a wealthy individual who is not hungry. It is the same behaviour, but the reasons for the behaviour will be different, and so consequently the perception of the response to it.

FACTORS THAT RESTRICT/DETERMINE BEHAVIOUR	FACTORS THAT ENCOURAGE AUTONOMY/CHOICE
- Lack of income; poverty	- Wealth
- Physical/mental disabilities/restrictions	- Physical health
- Influence of social demands/expectations (eg: social roles)	- Willingness to transgress social norms
- Lack of choice in past/negative past experiences	- Positive choice and experiences in past
- Genes that limit flexibility	- Genes that encourage flexibility
- Restraints in society (eg: discrimination)	- Social equality
- Factors limiting opportunities (eg: lack of education)	- Factors that encourage opportunities (eg: education)
- Factors from past that limit flexibility (eg: maternal deprivation)	- Factors from past that encourage flexibility (eg: positive attachments)
- Severe mental illness	- Lack of severe mental illness
- Strong habits/addiction	- Flexibility of thought/no addiction
- Unconscious determinism/lack of conscious awareness/lack of self-reflection	- Conscious awareness/ability to self-reflect

Table 1 - Factors that influence autonomy and determinism.

It is also possible that individuals will behave differently in varied situations if there are different factors influencing autonomy and determinism: for example, helping another person when alone, but ignoring them when in a group.

A variation on autonomy is the situation where individuals try to avoid having choice. This is because

"exercising autonomy involves taking responsibility for or 'owning' one's own actions" (Stevens 1996b). This can be frightening, and leads to an avoidance of this responsibility. Erich Fromm (1980) called it the "fear of freedom".

Individuals "decide" to give over their autonomy to others either to an authority figure or to follow the majority. The former is seen in the submission to an authoritarian regime and belief system either political or religious (eg: cults). Following the majority is seen in the fashion-chasing of "consumer capitalism". In both cases, the individual "wants" to be determined because they are no longer responsible for their choices and the consequences.

MISTREATMENT OF OTHERS AND CHOICE

It seems obvious from the outside that individuals who mistreat others have chosen to do so. There is a need to see them as sadists. If they did not choose the behaviour, then something personal determined them to be sadists. The tendency to see the individual as the cause of such behaviour is known as the fundamental attribution error (Ross 1977). But this is not necessarily right because internal factors may not be the cause of such behaviour.

Take the example of US soldiers found guilty of torturing Iraqi prisoners in Abu Ghraib prison, Iraq in 2004. One of them, Staff Sergeant Ivan Frederick was seen by the trial judge as choosing to do these things - in the sense of exercising free will (Bond 2007).

Philip Zimbardo, who was an expert witness on Frederick's defence team, argued that such extreme behaviour can be a product of situational factors. His original research in the 1970s, the Stanford Prison Simulation (Haney et al 1973), showed how ordinary students acting as "prison guards" in a mock jail became quite sadistic. Powerful social roles limit individual autonomy and determine certain behaviours.

Yet even within this type of situation, individuals can have some degree of choice despite it being very limited. For example, Joseph Darby, in the same US army company as Frederick, gave the photographs of the torture to his superiors despite the personal consequences. His family is now in hiding for fear of retaliation (Bond 2007). In both the cases of Frederick and Darby, it is not a question of autonomy/choice or determinism. It is a matter of degrees. Factors encourage or restrict autonomy and determinism, and an individual's "decision" is within that context. As to the degree of moral responsibility upon individuals in situations of limited choice that is

a philosophical question.

BIOLOGICAL DETERMINISM REMOVES FREE WILL?

With the increasing knowledge about human physiology (and particularly about the brain), there is a greater emphasis on how behaviour is determined by underlying biological processes. In other words, all behaviour is ultimately determined by physical processes.

Libet (1985) challenged any concept of free will or autonomy by showing that, for voluntary actions, there is a brain response 350 milliseconds before the individual reports consciously choosing to do an action. Thus the implication that "unconscious neuronal processes actually cause apparently volitional acts" (Fuchs 2006).

But, for Fuchs, experiments like this one, which reduce human activity to minute focuses, miss the wider aspects of meaning and intention. Whatever the actual amount of autonomy, and this may be a purely theoretical concept, individuals experience their lives. They place meaning upon their actions, and link this to their intentions. So, as important as the biological basis of the behaviour, is how the individual makes sense of the cause of their behaviour. This produces occasions where individuals claim autonomy, and others when they deny it - what can be called the "discourses of responsibility".

Irrelevant of the actual situation of autonomy, there are times when individuals use "I am in control" (taking responsibility) and others when "I couldn't help myself" (avoiding responsibility) is reported.

CONCLUSIONS

This model attempts a framework to understanding behaviour in terms of degrees of autonomy and determinism. But it is necessary to also take account of the meaning placed upon "choice" by the individual. In all situations there is some element of "choice" available, however limited it may be. The over-use of determinism of different types can easily be used to avoid responsibility.

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2. SELF-ESTEEM EQUILIBRIUM: TRYING TO EXPLAIN SELF-SABOTAGING BEHAVIOUR

There are cases of individuals, who generally have had negative experiences in their lives, then find a period of things going well. But after a short while of this, something happens to return the individual to the negative situation. It is like a "self-sabotaging behaviour" by the individuals when things are going well. "Self-sabotaging behaviour" means any behaviour, conscious or not, that causes a good situation for the individual to turn bad. I put the term in quotation marks because it is a contested concept, which needs exploring, but I am not going to do it here.

This everyday observation of what seems to happen to certain individuals, but I want to propose a mechanism by which it could occur. It can be called a self-esteem equilibrium.

A maximum level above which the individual cannot cope with things going well and a "switch" clicks producing the "self-sabotaging behaviour". It is almost a "what I deserve" level, and the individual is ill at ease if good things go beyond that level. Probably this level has been set by past experiences in the whole of childhood and in adulthood.

This idea can also be applied in the reverse for individuals who are used to good experiences in their lives and they start to experience negative things. Though it is less so here.

IDEAS FROM OTHER RESEARCH

The idea of a switch or an equilibrium is evident in other areas of psychology. Konrad Lorenz (1950) proposed the hydraulic model of instinctive behaviour. There is a build-up of action-specific-energy in a "reservoir", and when this is full, an appropriate trigger (known as a sign stimulus) leads to the release of the energy as a particular instinctive behaviour. For example, hunger (action-specific-energy) builds up, and at a certain level, the trigger of the appearance of the prey causes the predatory attack behaviour.

Applying this idea to the self-esteem equilibrium, the "reservoir" collects good experiences and good things in life, and when this is full, it triggers the "self-sabotaging behaviour". At this stage, I am not sure of the trigger or how the individual "knows" the "reservoir" is full.

Let us take this example. An individual with a history of unsuccessful personal relationships, starts dating someone new and all goes well. The individual's life is better, in many ways, than it has been. But, after a while, the individual becomes argumentative and critical, and very quickly the relationship ends. The individual returns once more to the negative state of affairs. It is as if they can only cope with a certain amount of happiness before the "deserving level" is reached and there is a need to return to unhappiness.

There is another idea that is relevant which was proposed to explain self-presentation - the sociometer theory (Leary and Downs 1995). A sociometer is a psychological mchanism that monitors how others see us and value us, and as necessary we adjust our behaviour to be accepted. The sociometer "operates more or less continuously outside of focal awareness" (Leary 2001 p462), and has an evolutionary benefit (ie: survival is easier as part of a group than alone).

In terms of the self-esteem equilibrium, the sociometer is monitoring the good things that are happening to the individual in relation to how much they deserve.

Figure 2 shows these ideas together in the self-esteem equilibrium.

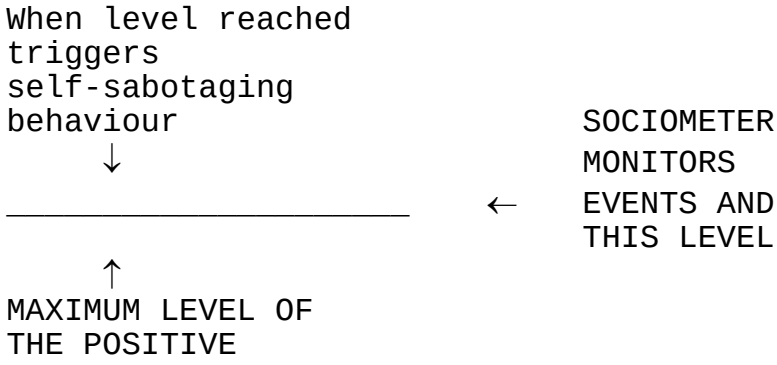

Figure 2 - Self-esteem equilibrium.

ISSUES

A number of questions arise from the idea of a self-esteem equilibrium.

i) How is the level or size of the "reservoir" established?

Undoubtedly, early experiences are important, particularly if the individual comes to believe that they do not deserve good experiences and positive things in their lives. But to avoid the psychodynamic pre-occupation with the first few years, I believe that this process can occur throughout childhood and into adulthood.

ii) Is the level set forever?

It would be depressing to think that individuals could not change. For individuals whose level is very low, that they feel they deserve very little good, then it will be harder to change. For them, any good experiences are a brief rest from the normality of the negative. But for other individuals, the level will be higher, and they can come to realise that it is not necessary to have a quota of good things.

iii) Is the "self-sabotaging behaviour" determined by the self-esteem equilibrium?

In terms of whether behaviour is determined and to what degree, I refer to part 1 of this article on autonomy and determinism. The lower the level, and the more negative the individual's past, the less autonomy they will have.

iv) Where is the process happening?

I would say that it is outside of focal conscious awareness, but not an unconscious (in the psychodynamic sense). It does mean that the individual can become aware of the process if they change their focus. Many aspects of behaviour are taking place outside of focal conscious awareness.

CONCLUSIONS

Most research on the self suggests that the concern is with positive self-presentation, and thus with positive experiences. Greenwald (1980) proposed that the ego is like a totalitarian government suppressing negative information about itself. Furthermore, "people not only want to feel good about themselves but need to do so" (Leary 2001).

What I am proposing is that certain individuals seek the negative. For a small group of people, there is a security to a life of negative experiences and unhappiness. Using the simple phrase, "better the devil you know than the devil you don't", some individuals cannot cope with positive experiences because it threatens their core notion of being undeserving of good things.

It is not that they are masochistic (ie: enjoying the negative), they do not like it, but it is the security of the predictable that matters. The world is easier to cope with when the predictable occurs - eg: I deserve only bad things, and only bad things happen to me. It is disturbing if good things start to happen because it is unpredictable, but also there is a fear of them inevitably stopping soon.

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Kevin Brewer

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IDEAS ABOUT EATING DISORDERS BY A SUFFERER OF AN EATING DISORDER - PART 2: COGNITIVE, PSYCHODYNAMIC AND LEARNING THEORIES

INTRODUCTION

This is the second of three articles on eating disorders. The first one (Peters 2006) looked at explanations based on personality characteristics, while this article focuses upon cognitive, psychodynamic, and learning explanations.

COGNITIVE THEORIES

Over the years, behavioural therapists have developed many models of eating disorders. From the 1970s emphasis was on fear of fatness and disturbances of body image, to the 1990s cognitive information processing theories.

According to this model, fears of fatness and body image are just small parts of a much wider construct. For example, overestimation of body size is seen as a cognitive bias, which comes from our self-schema related to body shape and size.

A study by Stein and Nyguist (2001) investigated the role of these self-schema in anorexia nervosa (AN) and bulimia nervosa (BN). Self-schema themselves are memory structures that hold information of particular importance, expertise, or meaningfulness to a person. They can be developed about any aspects of a person, including physical characteristics, personality traits, social roles. Once established in our memories they influence and regulate our behaviour.

As well as individual differences in self-schema, each one is also different in that it reflects a positive or negative characteristic of the self. For example, positive self-schema make it possible for us to have positive mood states , whilst negative self schema are associated with negative mood states and withdrawn behaviour (eg anxiety, feelings of fatness, depression, and self-loathing).

The study by Stein and Nyquist therefore hypothesised that people with eating disorders would have fewer positive self-schema in their memory than a control group. The results supported these ideas. Women in both AN and BN groups had fewer positive self schema compared to women in a control group (AN 57.5% of their self schema were positive, BN 60.5%, controls 82%). The groups also differed in the number of negative self schema (AN 29%, BN 28.4%, controls 7%). Thus supporting the idea

that a lack of positive self schema may contribute to the behaviours in eating disordered individuals.

Some theorists believe that over concern with body size/shape is what initially causes these "body self schema". The self schemata itself is thought to direct the person's attention to body and food-related stimuli, therefore biasing interpretation of events. For example, feelings of fullness might be interpreted as feeling fat, or a comment from a friend such as "You look well" may be interpreted as "If I look well I must have put on weight".

But if they are told they were looking ill and extremely thin on the other hand, they would use this as a reinforcement to lose more weight. These thoughts are not shared by "normal" people, because they do not process the same information in such a biased way. But to the eating disordered individual this body self schemata is so powerful that to them it is reality.

Results from other studies, such as the Stroop colour-naming task (Ben-Tovin and Walker 1991), and the dichotic listening task (Schotte et al 1991) suggested that individuals with eating disorders are more likely to focus on words implying a large physique, and ignore words implying a thin physique. Therefore showing the presence of attention (or cognitive) bias for body-related information among people with eating disorders.

The same results have been found in tests for memory bias (Vitousek and Hollon 1990) showing that eating disordered patients will store and access information in their memory that is related to weight and shape more easily than any other information.

One other bias concerning individuals with eating disorders is the selective interpretation bias. This suggests that when these individuals are exposed to information that can have two possible meanings, they will selectively interpret the information to fit in with their own beliefs.

As can be seen then, according to cognitive theories, the individual's most important worries lead to any information processing being totally biased in such a way that it is outside the individual's awareness.

THE FAMILY AND THE SELF

Disturbances in the development of the self have been identified as important factors in the development of eating disorders, thus being an important area on which to focus.

Hilde Bruch (1973) once argued that AN is caused by the failure to develop a diverse set of identities or

self-definitions. The adolescent is seen to turn to body weight as a means of compensating for the lack of clear identity and its associated feelings of powerlessness.

As individuals we can also develop a sense of who we are, and how we fit in, through interactions with our families. Parents might serve as role models, providing examples for attitudes, coping skills, and eating habits. It has been suggested that parents of anorectic children have high expectations of their offspring to compensate for the lack of love in their own marriage.

The anorectic may then use her illness to try and unite her parents. She may be seen as trying to keep the family together by providing the parents with an object of common concern which will stop them drifting apart. The eating disordered individual then becomes a scapegoat for the family, with the parents projecting their "bad selves" and any sense of inadequacy they might feel onto her. The individual may have such a huge fear of being abandoned that she will fulfil this function.

This leads to feelings that she is the centre of attention, in which case she feels she must please others due to the fact that she feels so inadequate.

There can, however, be more than one outcome if a mother focuses all her attention on her child's well-being, with over-involvement leading to separation difficulties in later life.

Casper (1987) spoke of the possibility of AN as a form of paranoia, where fears are projected into the body instead of into the outside world. he saw these fears as a representation of the child's failed attempt at individuation (or separation) from her parents. This again would lead to the child failing to develop its own independent existence. Thus refusing to eat is a kind of rebellion by the child, which enables her to assert some kind of independence.

Family Behaviour

The role of dysfunctional family interactions in the onset of AN has been given an important place in the field of research, with many researchers claiming that family dynamics are at the root of eating disorders. Rosman et al (1987), for example, said they had recognised a group of family system characteristics that reflect the family dynamics of patients with AN. These characteristics provide the framework for the anorectic child to use her illness as a way of communicating avoided messages. The four recognised characteristics were:

- Enmeshment - members of the family are highly involved

with one another. There will be excessive togetherness, intrusion on each other's thoughts, feelings and actions, weak family confines, and a lack of privacy. Perception of self and of other family members is unsuccessfully differentiated. This type of interaction is another cause of inability, on the child's part, to separate and individuate.

- Over-protectiveness - this refers to excessive nurturing and protective responses.

- Rigidity - within these types of family, any need for change is denied. Constant stable behaviour patterns are rigidly adhered to. At times when change is inevitable parents are reluctant to allow necessary changes in the family roles and rules. In this view AN is a symptom of a rigid family systems' need but inability to adapt to a new stage of development (eg an adolescent beginning to need more independence).

- Avoidance of conflict - any discussion over differences of opinion within the family is avoided. Problems are left unresolved, and feelings are not honestly acknowledged.

In their study, Rosman et al (1987) found that anorectic females showed extreme patterns of all these traits.

Parents who overvalue appearance can also in some way innocently contribute to a child's eating disorder. As can parents who make critical comments about their child's bodies, even as a joke.

AN daughters of mothers who are concerned with their own weight will also feel more pressure to keep losing weight. If to her the eating disorder is her one and only achievement/success, she will not want to be "out done" by anybody else. Therefore seeing others, especially family members, dieting will increase the pressure for her to lose weight. She may even use her family as a way of meeting her desire for food, through projective identification.

In this instance she would give to others what she is craving for herself. Her need for food is converted into satisfying the needs of others. This may relate to the idea that she feels she is not worthy of eating, because the part she plays in the family is of no use and that she contributes nothing. The needs of her parents or siblings, who are the real "workers", should therefore be the main priority.

Because BN has been recognised for a much shorter time than AN, there has been less research on its origins. However, one common theory is that bulimic women

lack the parental affection and involvement they need, therefore they soothe themselves with food as compensation. However, they later pay the price with strong feelings of shame and self-hatred for what they have done.

While eating disordered families can then be seen to have more disturbed interaction than normal families, many researchers would still agree that we should not come to hasty conclusions about eating disordered individuals and their families. However, despite any conflicting evidence, the importance of the relationship between eating disorders and family should not be overlooked. Whether or not a particular set of family characteristics are specific to AN, what is important is how the AN child perceives her parents' relationships, and her place in them.

When explaining these findings we do not need to view the family as a source or the origin of the problem. However, regardless of how the illness came about, its symptoms have become tangled with family relationships, causing many entire families to experience suffering and anguish.

PSYCHOANALYTIC THEORIES AND ATTACHMENT

Some theorists have seen the relationship between mother and infant, and the attachment process that occurs, as playing a causal role in the onset of eating disorders. Humphrey and Stern (1988; quoted in Wright 1997-2004), for example, suggested that the onset of an eating disorder was caused by several failures in the mother-infant relationship.

One failure was seen to be in the mother's ability to consistently comfort the child and care for her needs. Without this consistency the child will develop no sense of trust in the environment. The absence of this secure environment will lead to lack of individuation, which in turn will stop the child expressing intimacy, thus leading to the need to express her feelings in some other way, and in many cases in the form of an eating disorder.

Coonerty (1986; quoted in Wright 1997-2004) shared these ideas. His view was that a child's first attempts to individuate from the mother at around two years of age, then again during adolescence. If there is not successful individuation as a toddler, there will be extreme difficulties in the same attempt as an adolescent. She may then attempt to postpone adolescence by reducing her intake of food. These difficulties often lead to psychiatric disturbances.

It has been put forward by John Bowlby that eating

disordered individuals are insecurely or anxiously attached. According to his attachment theory (eg Bowlby 1969), an individual draws close to an attachment figure as a way of soothing their anxieties and attempting to feel secure. He believed that the eating disordered individual diets because she thinks by doing so she will create more secure relationships, thus lessening the tensions that she cannot handle.

Lerner (1983) also saw food , especially in BN, as symbolic of a failed mother-daughter relationship. With the avid ingestion of food representing the longing to return to an early stage of complete harmony between mother and infant. As a result, the child never develops a sense of ownership of her own body, and attempts to regain control by not eating.

In a comparison of eating disordered and non-eating disordered individuals, the fear of losing an attachment figure was the only ego deficit which was different. Supporting the idea of attachment as an effect on eating disorders (Becker et al 1987; quoted in Wright 1997-2004). This may be linked to explaining why eating disorders occur predominately in females.

Supporting this idea is Beattie's (1988; quoted in Wright 1997-2004) view, which states that eating disorders occur more in females because the mother projects her "bad self" onto her daughter. The mother may see her daughter as a narcissistic extension of herself, once again making it difficult for her daughter to individuate.

Beattie also perceived daughters as needing to remain close to their mothers as a way of achieving their sexual identity. Because daughters see themselves as having less control over their bodies than do sons, as a result daughters rely on their mothers more than sons.

This idea is one that was predominant in the early psychoanalytic theories. The majority of which see starvation as being symbolic of sexual conflicts (ie: that anorectic girls are denying an early childhood fear of impregnation by the father). Some of these early theories may seem very far-fetched nowadays, but at the time were a common idea among many.

Examples of this are the ideas of Falstein et al (1956). According to them, "Eating may be equated with sexual gratification, impregnation, intercourse, performance, pleasing the mother, growing; or it may represent castrating, destroying, engulfing, killing, or cannibalism. Food may symbolize the breast, the genitals, faeces, a parent, or a sibling" (quoted in Miller and Mizes 2000).

Sigmund Freud (eg 1905) wrote very little about eating disorders, however in what he did write, he attributes AN to traumatic childhood events. His ideas were mainly centred on childhood seduction and oral sex. So as in other early psychoanalytic ideas he too associated eating disorders to sexual instinct.

It was also suggested that at the stage of adolescence the child is unable to meet the demands of maturity, and reverts to a more primitive level at which oral gratification is associated with sexual pleasure. Thus anorexia is viewed as a defence against oral impregnation fantasies (and the anxiety generated by such fantasies), and bulimia is seen as an expression of unconscious desired for sexual gratification.

Through Freud's oral stage we could also surmise some relation to bulimia. For example, a baby learns to experience the world by putting things in its mouth, in hope that it will give her the same satisfaction that the mother's breast once did. Meaning the child hopes to attain pleasure by putting everything it can in its mouth (relating to bulimia). After this is Freud's anal stage with its focus on excretory functions. At this stage the parents are seen to give much attention (and encouragement) to potty training.

Therefore what the child takes into the body and what she expels out become central to her growing image of herself. Through both the oral stage then, with the child learning that what is put in the mouth may lead to satisfaction; and the anal stages' focus on expulsion and image, the child may unconsciously be learning things that may lead to the onset of eating disorders in later life (eg: Freud stated that holding back and expulsion are related to issues of control, orderliness, and neatness in later life).

LEARNING

Although the majority of these psychoanalytic ideas were prominent in the 1940s and 50s, learnt behaviour is still today seen as a possible cause for the onset of eating disorders. For example, the idea that BN patients as children were given food by their caretakers to lift their mood. Thus relating to the earlier idea that eating (or what you put in your mouth) leads to satisfaction.

Another form of learnt behaviour in eating disorder patients is seen in their response to anxiety and feelings of fatness. The individual will engage in a number of behaviours to avoid such feelings, for example, restrictive eating, compulsive exercise, self-induced vomiting. For a short time these behaviours will reduce feelings of anxiety, and the individual will see them as

useful or helpful, leading to reinforcement of the behaviours. Eventually though these compensatory behaviours that are being reinforced will confirm to the individual that she should fear fatness, and worry about body size and shape. Leading to an ongoing process.

One form of learning, called evaluative conditioning (1), is the process whereby an individual associates liking/disliking a stimulus based on the context in which it was given (De Houwer et al 2001). For example, if a piece of artwork is looked at whilst a person is experiencing positive emotions, the individual is more likely to report a liking for the picture. However, if the stimulus is viewed whilst negative emotions are present, the individual may report a dislike (2).

This can be applied in the context of eating disorders and dieting, leading to food preferences and rules. Eating disordered individuals, for example, may feel negative emotions such as anxiety, guilt, or shame whilst eating fattening foods, leading to a dislike for the food in question. Alternatively, consuming low-fat, low-calorie foods may reduce anxiety and provide temporary contentment, leading to the individual's preference for these foods.

Some research which has supported these ideas includes a report by Ruggerio et al (1988) who found that foods high in calories and fat were not preferred, and were avoided, by bulimics.

FOOTNOTES

1. Evaluative conditioning "is the transfer of affect from one stimulus to another through a conditioning paradigm" (Field 2000). It can occur without conscious awareness (Field 2000).

2. The technique used here is known as the (dis)liked picture pairing paradigm (Baeyens et al 1990).

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